Blue Shield of California
An Independent Member of the Blue Shield Association

APPLICATION FOR BLUE SHIELD MEDICARE SUPPLEMENT PLANS

Thank you for applying to Blue Shield of California. Please read the following information carefully before you complete the application. If your application is approved, the application and Statement of Health will become part of your plan contract. Coverage becomes effective following receipt and approval of your application and first month's payment. Blue Shield will send you an approval letter, Service Agreement and member I.D. card as proof of approval. **(Cashing of a check by Blue Shield does not constitute approval.)** Please follow the instructions so that we can process your application.

TO BE ELIGIBLE TO APPLY FOR A BLUE SHIELD MEDICARE SUPPLEMENT PLAN YOU MUST BE:

1. Enrolled under Federal Medicare Hospital Insurance (Part A) and Federal Medicare Medical Insurance (Part B).
2. A resident of the State of California.
3. If you are 64 or younger and entitled to Medicare on the basis of Social Security disability, DO NOT have End Stage Renal Disease and you qualify under the provisions of Blue Shield's Guaranteed Issue Guide, you may apply for any Blue Shield Medicare Supplement Plan. Those 64 or younger WITH End Stage Renal Disease are NOT eligible to enroll.

INSTRUCTIONS

- Provide **all** requested information.
- Print clearly in ink.
- Sign and date in all places indicated in section 4.
- Within 30 days of the applicant's signature date, return the application to your Blue Shield Agent, or mail it to Blue Shield of California's Underwriting Department. (If you lose the enclosed envelope, call Blue Shield at **(800) 837-4206** for the address of the office that will process your application.)
- **You are responsible for terminating your existing coverage. Do not do so until you have been advised by Blue Shield of California that you have been approved for coverage under this plan.**

Section One: APPLICATION INFORMATION

Part One: Personal Information

Social Security Number		Date of Birth
First Name	Middle Initial	Last Name
Home Mailing Address		
Home City	Home State	Home Zip
Home Telephone No. with Area Code ( )	E-mail	Home Fax No. with Area Code ( )
Billing Address (if different from above)		
Billing City	Billing State	Billing Zip
Language Preference ❑ English ❑ Spanish ❑ Chinese ❑ Other		

Part Two: Medicare Information

Please copy the following information exactly as it appears on your Medicare card.

NAME OF BENEFICIARY _____

MEDICARE CLAIM NUMBER _____ SEX _____

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) _____

MEDICAL (PART B) _____

Section Two: ELIGIBILITY QUESTIONS

Please answer the following questions to the best of your knowledge:

1. Do you have:
   a) A Blue Shield of California Medicare Supplement Plan and want to transfer to a different Blue Shield Medicare Supplement Plan ❑ **Yes** ❑ **No**
   b) A non-Blue Shield of California Medicare Supplement Plan, policy or contract (including a health care service plan contract) or ❑ **Yes** ❑ **No**
   c) A health maintenance organization (HMO) contract? ❑ **Yes** ❑ **No**
   d) If yes to b or c, with which company? _____
2. Do you intend to replace your current Medicare supplement plan, policy, or contract with a Blue Shield Medicare Supplement Plan? ❑ **Yes** ❑ **No**
   If so, please complete and return the Replacement form (not required if you are a Blue Shield Member changing plans).

Section Two (continued): **ELIGIBILITY QUESTIONS**

Please answer the following questions to the best of your knowledge:

3. Do you have any other health care coverage that provides benefits similar to this Blue Shield Medicare Supplement Plan? ❑ **Yes** ❑ **No**
   a) If yes, with which company? _____
   b) What kind of coverage? _____

4. Are you covered by Medi-Cal? ❑ **Yes** ❑ **No**
   a) As a Specified Low-Income Medicare Beneficiary (SLMB)? ❑ **Yes** ❑ **No**
   b) As a Qualified Medicare Beneficiary (QMB)? ❑ **Yes** ❑ **No**
   c) For other Medi-Cal benefits? ❑ **Yes** ❑ **No**

5. According to the scenarios described on the enclosed Guaranteed Issue Guide, do you qualify for guaranteed issue (automatic acceptance into a Blue Shield Medicare Supplement Plan)? ❑ **Yes** ❑ **No**
   a) If yes, please check which scenario applies to you.
   ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ 13 ❑ 14 ❑ 15

6. Which Blue Shield Medicare Supplement Plan do you choose?
   ❑ A ❑ B ❑ C ❑ D ❑ F ❑ H* ❑ I*

Requested Effective Date: _____ / _____ / _____

NOTE: If you are 64 or younger and entitled to Medicare on the basis of Social Security disability, DO NOT have End Stage Renal Disease and you qualify under the provisions of Blue Shield's Guaranteed Issue Guide, you may apply to enroll in any Blue Shield Medicare Supplement Plan. If you are 64 or younger and have End Stage Renal Disease you are NOT eligible to enroll.
*If you are enrolling in Plans H or I under **guaranteed issue,** attach proof of prior coverage.

Section Three: **STATEMENT OF HEALTH**

All applicants are required to complete this section. If you qualify for Guaranteed Issue, you will not be denied acceptance in a plan based on your health statement.

1. Have you, **within the past three years,** received treatment or been hospitalized for any of the conditions listed below? If "Yes," please explain the condition and date of treatment.

	Yes	No	Explain Condition	Date of Treatment
Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, senility, Alzheimer's, paralysis, stroke, etc.				
Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.				
Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.				
Gastrointestinal disorders such as liver cirrhosis, hepatitis B or C, ulcerative colitis, etc.				
Genitourinary disorders such as kidney failure, dialysis, etc.				
Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.				
Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy*				
Cancer or malignant tumors				
Other conditions not listed above				

*California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

Section Three (continued): STATEMENT OF HEALTH

2. Do you have a pacemaker or artificial heart valve or have you had transplant surgery or heart surgery such as angioplasty or bypass? If you answer "Yes," please explain the condition and date of surgery. ❑ Yes ❑ No	**Date of Surgery**
3. Have you been bed-ridden or confined to a hospital, nursing home, convalescent hospital or other institution **within the past three years?** If you answer "Yes" to any of the confinement conditions listed here, please explain the reason for confinement and date of confinement. ❑ Yes ❑ No	**Date of Confinement**

4. Are you currently taking medication? If you answer "Yes," please list all medications you are currently taking and the condition for which the medication is prescribed. ❑ Yes ❑ No

Medication	Explain Condition

Section Four: CONDITIONS OF MEMBERSHIP, ELIGIBILITY AND AUTHORIZATIONS

Conditions of Eligibility: Before you apply, it's important that you read the following eligibility information, then sign and date below in the required place:

1. You do not need more than one Medicare supplement plan, policy or contract.
2. If you purchase a Blue Shield Medicare Supplement Plan, you may want to evaluate your existing health coverage to decide if you need multiple coverages.
3. You may be eligible for benefits under Medi-Cal and may not need a Medicare supplement plan, policy or contract.
4. If requested, the benefits and dues under your Blue Shield Medicare Supplement Plan can be suspended for 24 months during your entitlement to benefits under Medi-Cal. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your plan will be reinstated, if requested, within 90 days of losing Medi-Cal eligibility.
5. Counseling services may be available in your area to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling services may be obtained from the State Department of Aging.

I UNDERSTAND THE ELIGIBILITY INFORMATION AND HAVE ANSWERED THE QUESTIONS IN SECTION TWO TO THE BEST OF MY KNOWLEDGE. I CERTIFY THAT I MEET THE ELIGIBILITY REQUIREMENTS OUTLINED. I HAVE ALSO RECEIVED A COPY OF THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AND A COPY OF THIS APPLICATION. ❑ Yes ❑ No

Conditions of Membership: Please read the following membership statements, then sign and date below in the required place:

1. This application will become part of the contract for which I am applying.
2. I will receive no coverage from Blue Shield unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.
3. Only Blue Shield can approve this application. A Sales Representative cannot grant approval, change terms or waive requirements.
4. Authorization for Disclosures of Personal Information:

I authorize any "provider of care," insurer, or health plan to disclose to Blue Shield of California, or their representatives, all "medical information" (as those terms are defined in the California Civil Code) regarding me, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for evaluating this application, determining eligibility for benefits, and/or for quality assurance and peer review. This authorization will remain valid for the term of coverage of the Blue Shield health service contract. A photocopy of this authorization is as valid as the original. My authorized representative and I are entitled to receive a copy of this authorization.

I HAVE READ THE SUMMARY OF BENEFITS AND THE ABOVE MEMBERSHIP CONDITIONS; I UNDERSTAND AND AGREE TO THEM. I ALONE AM RESPONSIBLE FOR THE ACCURACY AND COMPLETENESS OF THIS APPLICATION FOR BLUE SHIELD HEALTH COVERAGE. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

Applicant's Full Signature	Date	Applicant's Full Name *(please print legibly)*	Date
Solicitor's Signature (Broker or Sales Representative)	Date		

The solicitor's signature **does not** constitute approval for coverage.
Blue Shield will send you an approval letter, Service Agreement and member I.D. card as proof of approval.

Section Five: **BILLING INFORMATION**

After your application is approved, you will receive a bill indicating the amount and the date payment is due. *Do not include any payment with your application at this time.* For monthly dues information, refer to Blue Shield Medicare Supplement Plans' Summary of Benefits and Provisions.

Select Your Payment Choice:

❑ Easy$Pay℠ (automatic monthly debit – complete enclosed required form)	❑ Quarterly Billing	❑ Monthly Billing

Section Six: **BLUE SHIELD REPRESENTATIVE INFORMATION**

(to be completed by a Blue Shield Representative, if applicable)

Date			
Representative's Name			
Type of Representative	❑ Independent Agent/Broker	❑ Super Producer	❑ BSC Sales Representative
Representative's Social Security Number / Tax I.D. Number / BSC Code / Super Producer Code			
Representative's Address			
Representative's Telephone Number ( )	Representative's Fax Number ( )	Representative's E-mail Address	

1. Are you aware of information not disclosed in this application that may have a bearing on this risk? a) If you answer "Yes", please attach an explanation.	❑ Yes	❑ No
2. a) Did you see the applicant? b) Did you ask each question on this application exactly as set forth? (If you answer "No," please explain in the Additional Comments Section below.)	❑ Yes ❑ Yes	❑ No ❑ No
3. Are the answers recorded exactly as given to you?	❑ Yes	❑ No
4. Who completed this application?	❑ Rep	❑ Applicant

Representatives shall list any other health insurance policies or plan contracts they have sold to the applicant.

1. List all policies or plan contracts sold which are still in force.

2. List all policies or plan contracts sold in the past five (5) years which are no longer in force.

Additional Comments

Original : Give to Your Blue Shield Agent or Mail to Blue Shield's Underwriting Dept.
Yellow: Your Copy